

Part 208: Home and Community Based Services (HCBS) Long Term Care

Part 208 Chapter 7: 1915(i) HCBS Services

Rule 7.1: Eligibility

- A. The Division of Medicaid covers certain 1915(i) Home and Community-Based Services (HCBS) as an alternative to institutionalization in an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) through its State Plan. The State Plan services:
 - 1. Offer broad discretion, not generally afforded, so that the needs of beneficiaries under the State Medicaid Plan may be addressed,
 - 2. Are operated jointly with the Mississippi Department of Mental Health (DMH),
 - 3. Are available statewide,
 - 4. Carry no age restrictions, and
 - 5. Are covered only for beneficiaries not enrolled in any HCBS Waiver program.
- B. All of the following eligibility requirements must be met to receive 1915(i) State Plan services:
 - 1. A beneficiary must have one (1) of the following:
 - a) An intellectual disability defined by the Division of Medicaid as meeting all the following criteria:
 - 1) An IQ score of approximately seventy (70) or below,
 - 2) A determination of deficits in adaptive behavior, and
 - 3) Manifestation of disability prior to the age of eighteen (18).
 - b) A developmental disability defined by the Division of Medicaid as a severe, chronic disability which is a condition attributable to cerebral palsy, epilepsy, or any other condition other than mental illness found to be closely related to an intellectual disability, because it results in impairment of general intellectual functioning or adaptive behavior similar to that of an individual with an intellectual disability and requires similar treatment/services.
 - 1) The condition is manifested prior to age twenty-two (22) and is likely to continue indefinitely.

- 2) The condition results in substantial functional limitations in three (3) or more of the following major life activities:
 - i) Self-care,
 - ii) Understanding and use of language,
 - iii) Learning,
 - iv) Mobility,
 - v) Self-direction, or
 - vi) Capacity for independent living and economic self-sufficiency.
 - 3) The individual also requires a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of individually planned and coordinated assistance that is life-long or of an extended duration.
 - 4) An exception to this definition is an individual, from birth to age nine (9), who has a substantial developmental delay or specific congenital or acquired condition. He or she may be considered developmentally disabled without meeting all of the above criteria if, without services and supports, there is a high probability of meeting those criteria later in life.
 - c) Autism as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association.
2. Applicant must qualify for full Medicaid benefits in one (1) of the following categories:
- a) SSI,
 - b) Low Income Families and Children Program,
 - c) Disabled Child Living at Home Program,
 - d) Working Disabled,
 - e) Children Under Age Nineteen (19) Under 100% of Poverty,
 - f) Protected Foster Care Adolescents,
 - g) CWS Foster Children and Adoption Assistance Children,
 - h) IV-E Foster Children and Adoption Assistance Children, or

- i) Child under Age six (6) at 133% Federal Poverty Level.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.2: Provider Enrollment

- A. Division of Medicaid 1915(i) providers must be certified by the Mississippi Department of Mental Health (DMH), Bureau of Quality Management, Operations and Standards (BQMOS). DMH Certification is dependent upon compliance with the Mississippi Department of Mental Health Operational Standards.
- B. The provider must be in good standing with their state licensure agency and adhere to applicable state and federal regulations related to the license. The provider must comply with all rules and standards related to the 1915(i) services and have a current Mississippi Medicaid provider number.
- C. All providers must comply with the CMS approved 1915(i) State Plan.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.3: Freedom of Choice

- A. Medicaid beneficiaries have the right to freedom of choice of providers for Medicaid covered services. Refer to Part 200, Chapter 3, Rule 3.6.
- B. Case Managers must inform the beneficiary/legal representative of qualified providers initially and annually thereafter as well as when new qualified providers are identified or if a person is dissatisfied with their current provider.
- C. The choice made by the beneficiary/legal representative must be documented and signed by the beneficiary/legal representative and must be maintained in the beneficiary's record.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.4: Level of Care Evaluation/Reevaluation and Plan of Care Development

- A. Level of care (LOC) evaluations and reevaluations for eligibility must be conducted by one (1) of the five (5) Diagnostic and Evaluation (D&E) Teams housed at the DMH's five (5) comprehensive regional programs.

1. Re-evaluations are only required if the beneficiary has a significant change in condition.
 2. Evaluations and reevaluations must be conducted in an interdisciplinary team format which must include a psychologist and social worker.
 - a) Additional team members, including, but not limited to, physical therapists and dieticians, may be utilized dependent upon the needs of the individual being evaluated or reevaluated.
 - b) All members of the D&E Teams must be licensed and/or certified through the appropriate State licensing/certification body for their respective disciplines.
- B. An initial Person-Centered Plan of Care must be facilitated by the Case Manager and be reviewed at least every twelve (12) months and when there is a significant change in the beneficiary's circumstances that may affect his/her level of functioning and needs. The Case Manager must:
1. Have a minimum of a Bachelor's degree in a mental health/IDD related field and be credentialed by the MS Department of Mental Health or be a Qualified Mental Retardation Professional (QMRP)/Qualified Developmental Disabilities Professional (QDDP).
 2. Complete training in Person-Centered planning and demonstrate competencies associated with that process.
 3. Seek active involvement from beneficiaries and their families and/or legal guardians to develop and implement a plan of care that is person-centered and addresses the outcomes desired by the beneficiaries.
 4. Educate beneficiaries and their families and/or legal guardians about the person-centered planning process.
 5. Assist beneficiaries participating in 1915(i) and/or their family members and legal representatives to determine who is included in their planning process.
 6. Encourage the inclusion of formal and informal providers of support to the beneficiaries in the development of a person-centered plan.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.5: Covered Services

A. A beneficiary can receive:

1. 1915(i) services if not eligible for services available:
 - a) For Prevocational Services under a program funded under Section 110 of the Rehabilitation Act of 1973 or Sections 602(16) and (17) of the Individuals with Disabilities Education Act , 20 U.S.C. 1401 (16) and (17), or
 - b) For Supported Employment under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
 2. Only those 1915(i) services which are documented on the POC by the Case Manager and approved by the DMH/BIDD, and
 3. Multiple 1915(i) services on the same day but not during the same time of the day.
- B. Transportation between the beneficiary's residence, other habilitation sites and the employment site is a component part of Habilitation Services.
1. The cost of transportation is included in the rate paid to the provider.
 2. Providers cannot bill separately for transportation services and cannot charge beneficiaries for transportation.
- C. The 1915(i) State plan services are:
1. Day Support Services defined by the Division of Medicaid as services designed to assist the beneficiary with acquisition, retention, or improvement in self-help, socialization, and adaptive skills. Activities and environments are designed to foster the acquisition and maintenance of skills, building positive social behavior and interpersonal competence, greater independence and personal choice. Day Support Services:
 - a) Must take place in a non-residential setting separate from the home or facility in which the beneficiary resides.
 - b) Must be furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week, or as specified in the beneficiary's POC.
 - c) Must provide a mid-morning snack, a nutritious noon meal, an afternoon snack, and offer choices of food and drink even though the meals provided as part of this service do not constitute a "full nutritional regimen".
 - d) Must be provided in DMH certified sites /community settings.
 2. Prevocational Services defined by the Division of Medicaid as services to prepare a beneficiary for paid employment. Services address underlying habilitative goals which are associated with performing compensated work. Services include, but are not limited

to, teaching concepts such as compliance, attendance, task completion, problem solving and safety. Services are not job task oriented but instead are aimed at a generalized result. Prevocational Services:

- a) Must be included in the beneficiary's Plan of Services and Supports and be directed towards habilitative objectives and not explicit employment objectives.
 - b) Providers are not required to provide meals but must have procedures to ensure food/drink is available for beneficiaries, if necessary.
 - c) May include personal care/assistance as a component but it cannot comprise the entirety of the service. Beneficiaries cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.
 - d) Beneficiaries must be compensated in accordance with applicable federal laws and regulations. If a beneficiary is performing productive work as a trial work experience that benefits the provider or that would have to be performed by someone else if not performed by the beneficiary, the provider must pay the beneficiary commensurate with members of the general work force doing similar work per federal wage and hour regulations.
 - e) Must be reviewed for necessity and appropriateness by the beneficiary, appropriate staff and the Case manager if the beneficiary earns more than fifty percent (50%) of the minimum wage.
 - f) Providers must inform beneficiaries about Supported Employment opportunities and other competitive employment activities in the community on an annual basis.
 - g) May be furnished in a variety of locations in the community and are not limited to fixed program locations. Community job exploration activities must be offered to each beneficiary at least one (1) time per month.
 - h) Include transportation. Time spent in transportation to and from the program cannot be included in the total number of service hours provided per day, unless it is for the purpose of training.
3. Supported Employment services defined by the Division of Medicaid as intensive, ongoing support to beneficiaries who, because of their disabilities, require support to obtain and maintain an individual job in competitive or customized employment, or self-employment. Employment must be in an integrated setting in the general workforce for whom a beneficiary is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Supported Employment:
- a) Is based on an Activity Plan that must be developed for each beneficiary based on his/her Plan of Care.

- b) Includes assessment, job development and placement, job training, negotiation with prospective employers, job analysis, systematic instruction, and ongoing job support and monitoring.
- c) Includes services and supports to assist the beneficiary in achieving self-employment through the operation of a home or community based business, and may include the following:
 - 1) Aiding the beneficiary in identifying potential business opportunities.
 - 2) Assisting in the development of a business plan, including potential sources of financing and other assistance in developing and launching a business.
 - 3) Identifying supports necessary for the beneficiary to successfully operate the business.
 - 4) On-going assistance, counseling and guidance once the business has launched.
- d) Cannot use Medicaid funds to defray the expenses associated with starting or operating a business.
- e) Must be provided at work sites where persons without disabilities are employed and where payment is made only for the adaptations, supervision, and training required by beneficiaries receiving 1915(i) services and does not include payment for the supervisory activities rendered as a normal part of the business setting.
- f) Must include transportation between the beneficiary's place of residence and the site of the beneficiary's job or between or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component of supported employment. Transportation cannot comprise the entirety of the service.
- g) May include personal care/assistance as a component of Supported Employment but cannot comprise the entirety of the service.
- h) Do not include sheltered work or other similar types of vocational services furnished in specialized facilities or volunteer work.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.6: Serious Events/Incidents and Abuse/Neglect/Exploitation

- A. Case Managers and DMH providers must receive training at least annually regarding Mississippi's Vulnerable Persons Act.

1. The training must include what constitutes possible abuse/neglect/exploitation, who must report, and the procedures for reporting and the consequences of not reporting.
 2. Providers are required to receive training about reporting Serious Incidents to the DMH/BQMOS.
- B. Providers must provide the beneficiary/legal guardian with both the provider's and DMH's procedures for protecting beneficiaries from abuse, neglect, exploitation, and any other form of potential abuse.
1. The procedures must be provided upon admission and at least annually thereafter.
 2. The procedures must be given orally and in writing.
 3. Documentation must include the beneficiary/legal guardian's signature indicating the rights have been explained in a way that is understandable to them.
 4. The beneficiary/legal guardian must be given instructions for reporting suspected violation to the DMH, Office of Consumer Support (OCS) or Disability Rights Mississippi.
 5. The DMH toll free Helpline must be posted in a prominent place throughout each program site and provided to the beneficiary/legal representative.
- C. All providers must have a written policy for documenting and reporting all serious events/incidents. Documentation regarding serious events/incidents must include:
1. A written description of events and actions,
 2. All written reports, including outcomes, and
 3. A record of telephone calls to DMH/BQMOS.
- D. Serious events/incidents involving program services or program staff on program property or at a program-sponsored event must be reported to DMH/BQMOS, the agency director, and the parent/guardian/legal representative/significant person as identified by the beneficiary receiving services. Documentation regarding the event/incident must be maintained in a central file on site.
- E. Serious events/incidents must be reported to the DMH/BQMOS within twenty-four (24) hours, or the next business day, by telephone or written report. If the incident is reported by telephone, the provider must submit a completed report within five (5) business days.
- F. DMH must submit a summary of serious incidents/events to the Division of Medicaid with each quarterly report.

- G. Certain serious events/incidents involving beneficiaries that must be reported to the DMH/BQMOS and other appropriate authorities within twenty-four (24) hours or the next working day, include, but are not limited to, the following:
1. Suicide attempts on program property or at a program-sponsored event.
 2. Suspected abuse/neglect/exploitation, which must also be reported to other authorities in accordance with State law.
 3. Unexplained absence from a residential program of twenty-four (24) hour duration.
 4. Absence of any length of time from an adult day center providing services to beneficiaries with Alzheimer's disease and/or other dementia.
 5. Death of a beneficiary on program property, at a program-sponsored event or during an unexplained absence from a residential program site.
 6. Emergency hospitalization or emergency room treatment of a beneficiary receiving 1915(i) services.
 7. Accidents which require hospitalization and may be related to abuse or neglect, or in which the cause is unknown or unusual.
 8. Disasters including fires, floods, tornadoes, hurricanes, earth quakes and disease outbreaks.
 9. Use of seclusion or restraint.
- H. If a provider has any question whether or not a situation/incident should be reported, the provider must contact DMH/BQMOS.
- I. Reporting guidelines are determined by the setting in which the suspected abuse/neglect/exploitation occurred.
1. Suspected abuse/neglect/exploitation that occurs in a home setting must be reported to the Vulnerable Adults Unit (VAU) at the Attorney General's Office and the Division of Family and Children Services (DFCS) at the Mississippi Department of Human Services (DHS).
 2. Complaints of abuse/neglect/exploitation of beneficiaries in health care facilities must be reported to the Medicaid Fraud Control Unit (MFCU), Office of the State Attorney General (AG) and to the Mississippi Department of Health.
 3. Suspected abuse/neglect/exploitation that occurs in any Day Support services facility, which Division of Medicaid defines as a community-based group program for adults designed to meet the needs of adults with impairments through individual Plans of Care,

which are structured, comprehensive, planned, nonresidential programs providing a variety of health, social and related support services in a protective setting, enabling beneficiaries to live in the community must be reported to the DMH/BQMOS if the facility is certified by the DMH.

4. If the alleged perpetrator carries a professional license or certificate, a report must be made to the entity which governs their license or certificate.
5. Disease outbreaks at a provider site must be reported to Mississippi State Department of Health (MSDH).

Source: Miss. Code Ann. §§ 41-4-7, 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.7: Documentation and Record Maintenance

- A. Documentation of each service provided must be in the case record. Refer to Maintenance of Records Part 200, Ch.1, Rule 1.3.
- B. The entry or service note must include all of the following documentation:
 1. Date of service,
 2. Type of service provide,
 3. Time service began and time service ended,
 4. Length of time spent delivering service,
 5. Identification of beneficiary(s) receiving or participating in the service,
 6. Summary of what transpired during delivery of the service,
 7. Evidence that the service is appropriate and approved on the Plan of Care, and
 8. Name, title, credential, and signature of individual providing the service.
- C. Documentation/record maintenance for reimbursement purposes must, at a minimum, reflect the following:
 1. Documentation requirements in the CMS approved 1915(i) State Plan Amendment,
 2. DMH Operational Standards,
 3. Evidence that the service is appropriate and approved on the Plan of Care, and

4. Documentation requirements in the DMH Record Guide.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.8: Grievances and Complaints

- A. The Department of Mental Health, Office of Consumer Support (DMH/OCS) is responsible for investigating and documenting all grievances/complaints regarding all programs operated and/or certified by DMH. The DMH, Quality Management Workgroup assists the OCS in development of procedures for receiving, investigating, and resolving the grievances/complaints.
- B. Personnel issues are not within the purview of DMH/OCS.
- C. A toll-free Helpline must be available twenty-four (24) hours a day, seven (7) days per week. All providers are required to post the toll-free number in a prominent place throughout each program site.
- D. Providers of 1915(i) services must cooperate with both DMH and the Division of Medicaid to resolve grievances/complaints.
- E. Request for reports generated through the Information and Referral Database must be made through the Director of BQMOS.

Source: Miss. Code Ann. § 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.

Rule 7.9: Appeals and Hearings

- A. If it is determined that a beneficiary does not meet 1915(i) eligibility criteria or decisions made by the DMH/BIDD result in services being denied, terminated, or reduced the beneficiary/legal representative has the right to request an appeal.
 - 1. The beneficiary/legal representative has thirty (30) calendar days from the date of the notification of the denial of eligibility or denial, termination or reduction of services to submit an appeal in writing to the Director of BIDD. The beneficiary/legal representative may submit justification with the appeal. The notification must be included with the appeal.
 - 2. The Director of BIDD must respond in writing within thirty (30) calendar days of receipt of the appeal. If sufficient justification was not submitted with the appeal, the Director may request additional information and the time line will be extended an additional thirty

(30) days.

3. If the Director of BIDD decides that the denial of eligibility or denial, termination or reduction of services should be reversed, the beneficiary/legal representative will be notified in writing and all services will remain the same.
 4. If the Director of BIDD upholds the denial of eligibility or denied, terminated or reduced services the beneficiary/legal representative will be notified in writing.
 5. The beneficiary/legal representative may then appeal to the DMH Executive Director. The appeal must be in writing and must be submitted within thirty (30) calendar days of the date on the notification from the Director of DMH/BIDD.
 6. The DMH Executive Director must respond in writing within thirty (30) calendar days. If sufficient justification was not submitted with the appeal, the Executive Director may request additional information and the time line will be extended an additional thirty (30) days.
 7. The beneficiary/legal representative will receive written notification of the DMH Executive Director's decision.
 8. If the beneficiary/legal representative disagrees with the decision made by the DMH Executive Director a written request to appeal the decision may be made to the Executive Director of the Division of Medicaid. Refer to Chapter 1, Rule 1.3, of Part 300 Appeals.
- C. Appeal documentation and final determination(s) are filed by DMH/BIDD and the Division of Medicaid.
- D. During the appeals process, contested services must remain in place, unless the decision is made for immediate termination due to immediate or perceived danger, racial discrimination or sexual harassment by the service providers. The Case Manager is responsible for ensuring that the beneficiary continues to receive all services that were in place prior to the notice of change.
- E. Providers who must be certified by the DMH/BQMOS may appeal issues related to certification to DMH as outlined in the DMH Operational Standards and Administrative Code.

Source: Miss. Code Ann. §§ 41-4-7, 43-13-121; Social Security Act § 1915(i).

History: New to correspond with SPA 2013-001 (eff. 11/01/2013) eff. 12/01/2013.